

STATE OF WASHINGTON  
DEPARTMENT OF LABOR AND INDUSTRIES  
PO Box 44261 Olympia, Washington 98504-4261

**BILLING INSTRUCTIONS – STATE FUND CLAIMS  
STATEMENT FOR MISCELLANEOUS SERVICES  
BILL FORM  
F245-072-000**

\*\*\*\*\*

*Advanced Registered Nurse Practitioner,  
Certified Registered Nurse Practitioner, Registered Nurse,  
Dental Services, Durable Medical Equipment,  
Drug & Alcohol Treatment, Licensed Massage Therapy,  
Nurse Case Management, Obesity Treatment,  
Occupational Therapy, Optometry/Optician Services,  
Vocational Rehabilitation Services*

\*\*\*\*\*

## Table of Contents

BILLING INSTRUCTIONS	3
L&I Provider Account Number Required:	3
Billing on Paper Forms:	3
Bill Forms – Where and How to get them:	3
Billing Electronically:	3
When to Submit Bills:	3
When payments are made:	4
Limits on Bill Processing:	4
For Help:	4
PROVIDER SPECIFIC INSTRUCTIONS	5
Advanced Registered Nurse Practitioner	5
Certified Registered Nurse Practitioner	5
Registered Nurse	5
Dental Services	5
DME & Other Services	6
Drug & Alcohol Treatment	6
Licensed Massage Therapy	7
Nurse Case Management	8
Obesity Treatment	16
Occupational Therapy	16
Optometry/Optician Services	17
Vocational Rehabilitation Services	17
COMPLETING THE “STATEMENT FOR MISCELLANEOUS SERVICES” FORM	22
REBILLS	41
ADJUSTMENTS	41
TYPE OF SERVICE CODES:	45
PLACE OF SERVICE CODES:	45
FIELD SERVICE OFFICES	46

## **BILLING INSTRUCTIONS**

Labor and Industries (L&I) processes all provider bills using an automated system called the Medical Information Payment System (MIPS). In order to process your bills promptly and accurately, they must be completed as described in these instructions. Improperly submitted bills will be denied or returned for completion or correction.

For billing requirements for Self-Insurers and their service companies contact the Self-Insurance section at 360-902-6901.

### **L&I Provider Account Number Required:**

If you do not have an L&I provider account number, please call Provider Accounts at (360) 902-5140 to request a provider application form. This form and several other of the most frequently requested forms can also be downloaded from our website at [www.wa.gov/lni/forms](http://www.wa.gov/lni/forms). You may also request additional forms from your local field service location; a listing of these locations is contained on the last page of this billing instruction booklet. Submit your bill after you receive your L&I provider account number or for your first submission only, attach it to your completed application.

### **Billing on Paper Forms:**

Submit charges on the Department's "Statement for Miscellaneous Services" bill form (F245-072-000).

Mail "Statement for Miscellaneous Services" bill forms to:

Department of Labor and Industries  
PO Box 44267  
Olympia, Washington 98504-4267

### **Bill Forms – Where and How to get them:**

Bills must be submitted on ORIGINAL (not photocopied) Statement for Miscellaneous Services bill forms. Bill forms are furnished free of charge to providers. To order forms, contact the Labor and Industries Field Service Location office nearest you; a listing of these locations is contained on the last page of this billing instruction booklet. Providers outside Washington State may contact Provider Accounts at (360) 902-5140 or the Provider Hotline at 1-800-848-0811. When ordering, give your full name, address, L&I provider account number, quantity needed for six months, and the L&I form number (FXXX-XXX-000 for single sheet, or FXXX-XXX-111 for continuous pinfeed).

### **Billing Electronically:**

Please contact the Electronic Billing Unit at (360) 902-6511 or (360) 902-6512 if you are able to and are interested in submitting bills electronically.

### **When to Submit Bills:**

You should submit bills at the time the first required report is written. Billings should then be sent every 30 days thereafter until the conclusion of services. A separate bill form must be completed for each claim number but each bill form may contain more than one date of service. All dates of service must be billed separately.

**When payments are made:**

The department issues warrants to providers every two-weeks for bills that have processed to final status. An L&I Remittance Advice is also provided to you at two-week intervals. Remittance Advices provide a report of the status of your bill(s) that have been processed, or are in process. When contacting the department with a billing problem, please have the appropriate copy of the Remittance Advice in hand before calling. Many billing questions can be answered by reading the Remittance Advice.

Credit Balance Bills (CRE) – The bills will be held in abeyance until the credit balance is satisfied. These bills should be treated as “Bills in Process”. Do not post or rebill these bills as long as they appear in this section. **This is money owed to the department.** Payment(s) to clear your credit balance should be mailed to:

Department of Labor and Industries  
Cashier's Office  
PO Box 44835  
Olympia WA 98504-4835

**Limits on Bill Processing:**

Bills must be received within one year of the date of service to be considered for payment. Rebills must be submitted for services denied if a claim was closed and subsequently reopened or if a claim or diagnosis was rejected and subsequently allowed. In these instances, the rebill must be received within one year of the date the final order is issued, which subsequently reopens or allows the claim or diagnosis.

**For Help:**

If you have questions about “PAID BILLS”, “DENIED BILLS” or “ADJUSTMENT BILLS”, please call the Provider Hotline at 1-800-848-0811. **Please have a copy of the appropriate Remittance Advice in hand before calling.**

If you have questions about “BILLS IN PROCESS”, please call the automated Claim Information line at 1-800-831-5227, for up to the minute bill status. From that line, you may choose the “zero” option to be connected to the Bill Payment Unit.

If you have general questions about an injured workers claim or time-loss payment, please call the automated Claims Information line at 1-800-831-5227. More than one claim number can be accessed per phone call and any ‘wait time’ is minimal.

If an injured worker has general questions about their claim, please give them the 1-800-831-5227 number or the 1-800-LISTENS (547-8367) number for assistance with claim problems including time-loss. If they have bill questions, you may give them the Provider Hotline number 1-800-848-0811.

**Note: A completed Report of Accident does not constitute a bill. Bills must be submitted separately to be considered for payment.**

## PROVIDER SPECIFIC INSTRUCTIONS

### **Advanced Registered Nurse Practitioner** **Certified Registered Nurse Practitioner** **Registered Nurse**

Type of Service:

Use Type of Service code “N”

#### **Advanced Registered Nurse Practitioner**

Licensed nursing rules and billing instructions are contained in WACs 296-23-240 and -245. ARNP services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician.

#### **Certified Registered Nurse Anesthetists**

Licensed nursing rules and billing instructions are contained in WACs 296-23-240 and -245. CRNA services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician. The only modifiers that are valid for CRNAs are -QX and -QZ.

Please also refer to the “Anesthesia Payment Policies” section of the current fee schedule.

#### **Registered Nurse as Surgical Assistants**

Licensed registered nurses may perform surgical assistant services if the registered nurse submits all of the following documents to the department or Self-Insurer:

- A photocopy of her or his valid and current registered nurse license, and
- A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is **ninety** percent (90%) of the allowed fee that would otherwise be paid to an assistant surgeon (physician).

For further information please refer to WAC 296-23-240 & WAC 296-23-245

### **Dental Services**

Type of Service:

Use Type of Service code “4” if billing Level II HCPCS code(s). These codes begin with the letter “D”, followed by 4 numbers (e.g., D0120). See the HCPCS section in the current fee schedule for a listing of codes.

Use Type of Service code “3” if billing Level I CPT code(s). These codes consist of 5 numbers (e.g., 99201). See the Medicine section in the current fee schedule for a listing of codes.

Copies of the HCPCS Level I and II codes may be purchased from:

The Superintendent of Documents  
United States Government Printing Office  
Washington DC 20402

### **DME & Other Services**

(Includes Hearing Aid Fitter/Dispensers, Audiologists, Interpreters, Ambulance, Public Transportation)

Type of Service:

Use Type of Service code “9” on the Statement for Miscellaneous Services form when billing for durable medical equipment or any of the above services listed.

Modifier Codes:

Use modifier code “RR” for rental items.

Use modifier code “RP” for replacement and repair.

Pharmacies and durable medical equipment providers may bill for supplies and equipment with appropriate HCPCS and local codes. Delivery charges, shipping and handling, tax, and fitting fees are not payable separately. DME suppliers should include these charges in the total charge for the supply. For taxable items, an itemized invoice may be attached to the bill, but is not required.

DME suppliers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account number. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps.

TENS units (Transcutaneous Electrical Nerve Stimulators) and supplies are paid under special contract only. Refer to the section on “Transcutaneous Electrical Nerve Stimulators (TENS)” in the current fee schedule under “Specialty and Administrative Services” section.

For further information on miscellaneous services and appliances, refer to WAC 296-23-165.

### **Drug & Alcohol Treatment**

Type of Service:

Use Type of Service code “9” and the Local codes listed later in this section when billing for drug and alcohol rehabilitation services.

Use Type of Service code “3” and standard CPT codes when billing for laboratory procedures.

**WAC 296-23-185 Drug and alcohol rehabilitation services.** Authorization requirements for these services may be found in WAC 296-20-03001 and 296-20-055. Please refer to the provider bulletin listing in the current fee schedule for any information updates. If you would like to obtain a copy of the most current provider bulletin, please call the Health Service Analysis section at (360) 902-6799.

0141M	Intake Evaluation
0142M	Physical Examination
0143M	Individual Therapy, Routine Visit
0144M	Individual Therapy, Brief Visit
0145M	Group Therapy
0146M	Chemotherapy
0147M	Medication Adjustment
0149M	Detoxification facility (room & board)

## **Licensed Massage Therapy**

Type of Service:

Use Type of Service code “9” and procedure code 97124 when billing for Massage Therapy Services.

**Note: DO NOT bill services spanning multiple dates. Bill one date per line.**

Massage therapists are allowed to bill only one CPT code for massage (97124). 97124 is a timed code with a 15 minute value. Massage therapists should bill their usual and customary fee and designate the duration of the massage therapy treatment by the number of units in the ‘UNIT’ field.

Units are measured as follows:

1 unit	= 15 minutes
2 units	= 30 minutes
3 units	= 45 minutes
4 units	= 1 hour

The department will not reimburse massage therapists for additional costs that are not specifically allowed. Application of hot and cold packs, anti-friction devices and lubricants (e.g., oils, lotions, emollients, etc.) are bundled, and are not payable separately.

“No inpatient massage therapy treatment will be allowed when such treatment constitutes the only or major treatment received by the worker. See WAC 296-20-030 for further information.”

Refer to WAC 296-23 for additional information.

### **Authorization Required:**

“Massage therapy treatment will be permitted when given by a licensed massage practitioner only upon written orders from the worker's attending doctor.” (WAC 296-23-250)

“Massage therapy in the home and/or places other than the practitioners usual and customary business facilities will be allowed only upon prior justification and authorization by the department or self-insurer.” (WAC 296-23-250)

“Massage therapy treatments exceeding once per day must be justified by attending doctor.” (WAC 296-23-250)

Please refer to WAC 296-23-250 for additional information and reporting requirements.

## **Nurse Case Management**

### Type of Service:

Use Type of Service “9” with Local codes 1220M – 1225M when billing for Nurse Case Management Service.

All nurse case management services require prior authorization. Please refer to PB 98-01 for Payment Policy for Nurse Case Management Services. To request a copy of the current provider bulletin, please call (360) 902-6799 or can be viewed/downloaded from [www.wa.gov/lni/hsa/hsa\\_pbs.htm](http://www.wa.gov/lni/hsa/hsa_pbs.htm).

Nurse case management services are capped at 50 hours of service including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases contingent upon review by the insurer.

### CASE NOTE INSTRUCTIONS

A case record will be created and maintained on each claim. The case record shall present a chronological history of the injured worker’s progress in Medical Case Management services. A case manager’s services can be denied or reduced if the required documentation is not provided in the case notes or if the service does not match the procedure code billed.

Case notes shall be written when a service is given and shall specify:

- 1) When a service was provided,
- 2) What type of service was provided, using case note codes (See Attachment A),
- 3) A description of the service provided including person(s) involved, outcome, and future plan, if applicable and
- 4) How much time was used.

Copies of reports, correspondence, and expenses shall be maintained in the case record.

Case note codes will be used to document the type of services provided to or on behalf of the injured worker. Case note codes, including case note documentation requirements are explained fully in Attachment A. The table below describes the case note and billing codes. New maximum allowable fees are also noted.

<b>CASE NOTE CODES</b>	<b>BILLING CODES</b>
PCW, PCD, PCE, PCV, PCP, and PCO	1220M – Phone Calls Per Unit
VW, VD, VE, VV, VP, and VO	1221M – Visits Per Unit
CR, FRV, COR, RE, RW, RR, and TC	1222M – Case Planning Per Unit
TR, WA	1223M – Travel/Wait Per Unit
N/A	1224M – Mileage per mile
N/A	1225M – Expenses at Cost (includes parking, ferry, cab, toll fees, lodging and airfare)

\* - 1 unit equals 6 minutes of time. Per unit amounts are multiplied by 10 to equal the rate per hour.

Case note codes shall be converted to billing codes as bills are processed by the nurse case manager or firm. For example, all time associated with telephone calls during a 30-day period is added, converted



to units of service and then total charges. Likewise, all time associated with visits during a 30-day period is added, converted to units of service and then total charges, etc. Examples below describe how to convert time to units and calculate total charges. Examples are also shown for mileage and expenses.

### **Phone Calls, Visits or Case Planning:**

#### Step 1 – Time to Units

Total minutes divided by 6 = Total No. of Units	102 minutes/6 = 17 units
-------------------------------------------------	--------------------------

#### Step 2 – Units of Total Charges

Total units time per unit charge = Total charges	17 units x \$8.09 = \$137.53
--------------------------------------------------	------------------------------

### **Travel / Wait:**

#### Step 1 – Time to Units

Total minutes divided by 6 = Total No. of Units	150 minutes/6 = 25 units
-------------------------------------------------	--------------------------

#### Step 2 – Units to Total Charges

Total units times per unit charge = Total charges	25 units x \$3.98 = \$99.50
---------------------------------------------------	-----------------------------

### **Mileage:**

Mileage is reimbursed at the Washington State rate for mileage reimbursement. The current amount is \$.35 per mile. Mileage during a 30-day period is added then multiplied by .35 to obtain the total mileage expenses for the month. For example:

$$112 \text{ miles} \times .35 = \$39.20$$

### **Expenses:**

Expenses will be reimbursed at cost. Receipts for expenses shall be maintained in the case record. Receipts for parking are not required, but preferred. All expenses with a 30-day period shall be added, then coded as 1225M on the Statement for Miscellaneous Services bill form.

Attachment B describes covered and non-covered medical case management expenses.

An example follows:

$$\$5.00 \text{ (parking)} + \$7.50 \text{ (records)} = \$12.50$$

## ATTACHMENT A CASE NOTE CODES

### Phone Calls

- PCW: Injured worker, family members, injured workers' attorney or legal representative.
- PCD: Department of Labor and Industries staff.
- PCE: Employer or employer representatives.
- PCV: Vocational rehabilitation counselors.
- PCP: Attending physician, physician consultants, and other allied healthcare personnel.
- PCO: Governmental agencies, social services, community and/or volunteer resources, etc.

### Visits

- VW: Injured worker, family members, injured workers' attorney or legal representative.
- VD: Department of Labor and Industries staff.
- VE: Employer or employer representative
- VP: Attending physician, physician consultants, and other allied healthcare personnel.
- VO: Governmental agencies, social services, community and/or volunteer resources, etc.

### Case Planning

- CR: Case Review: review and analyze current or new data between monthly reporting periods.
- FRV: File Record Review: review and analyze historical file documentation.
- COR: Correspondence: prepare correspondence, i.e., letters memo, fax.
- RE: Research: research medical literature, condition specific.
- RW: Report Writing: prepare monthly reports, i.e., initial, progress and closure reports and special reports.
- RR: Record Retrieval: obtain medical records, reports or evaluations.
- TC: Team Conference: participate in or conduct team conferences.

### Travel / Wait

- TR: Travel: travel to person being visited
- WA: Wait to meet with person(s) being visited.

Mileage      **Not applicable.**

Expenses      **Not applicable.**

## CASE NOTE CODES, DESCRIPTIONS AND INSTRUCTIONS

## PHONE CALLS

**Definition:** made by or to a nurse case manager for consultation, coordinating medical services or for case planning with the persons listed below. This service is to be used to clarify or alter previous instructions; to integrate new information from other health care professionals into the medical treatment plan; or to assess the need to modify or change the current treatment plan to facilitate the worker's recovery; to assess the success of current therapies or treatment, overall.

**Billing Instructions:** Bill 1 unit of service for each 6 minutes of time. Documentation of the service is to include a case note describing each instance when a service was performed and billed. The case notes will contain the date of the call, to whom the phone call was made, their title if applicable (MD, RN, DO, PT, etc.), the reason for the call, details of the discussion and length of phone call.

Billing coded and Descriptions:

PCW:	Includes phone calls to injured worker, family members, injured worker's attorney or legal representatives.
PCD:	Includes phone calls to Department of Labor and Industries claims managers, occupational nursing consultants, supervisors, and other department staff.
PCE:	Includes phone calls to employer or employer representatives to access information or facilitate return to work for the injured worker.
PCV:	Includes phone calls to vocational rehabilitation counselors for coordination of rehabilitation services.
PCP:	Includes calls to attending physician, physician consultants, and other allied health care personnel to facilitate health care service delivery.
PCO:	Includes phone calls to other governmental agencies, social services, community and/or volunteer resources to provide for the injured worker's health care needs.

## VISITS

**Definition:** Onsite meetings or scheduled face-to-face meetings by a nurse case manager for consultation, coordinating medical services or for case planning with the persons listed below. This service is to be used to clarify or alter previous instruction; to integrate new information from other health care professionals into the medical treatment plan; or to assess the need to modify or change the current treatment plan to further recovery; to assess the success of current therapies or treatment overall when telephonic services are not adequate to obtain the necessary information.

**Billing Instructions:** Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include a case note describing each instance when a service was performed and billed. The case notes will contain the date of the visit, who was visited, their title if applicable (MD, RN, DO, PT, etc.), the reason for the visit, details discussed and the length of visit.

### Billing Codes and Descriptions:

VW:	Includes visits with injured worker, family members, injured workers' attorney or legal representative.
VD:	Includes visits with the Department of Labor and Industries claims managers, occupational nursing consultants, supervisors, and other department staff.
VE:	Includes visits to employer or employer representatives to access information or facilitate return to work for the injured worker.
VV:	Includes visits with vocational rehabilitation counselors for coordination of rehabilitation services.
VP:	Visits with the attending physician consultants, and other allied health care personnel to facilitate health care service delivery.
VO:	Visits with other governmental agencies, social services, community and/or volunteer resources to provide for the injured worker's health care needs.

## CASE PLANNING

### 1) Case Review (CR)

Definition / Billing Instructions: The time taken to review and analyze current or new data between monthly reporting periods; includes documentation of impact of new data on overall case plan. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include the date, case note with the data and description of the data, analysis, and plan. Case planning is not to be billed for writing case notes to document onsite visits or phone calls. Phone calls and visits already include payment for associated documentation.

### 2) File Record Review (FRV)

Definition / Billing Instructions: The time taken to review and analyze historical file documentation at the onset of referral to medical case management. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include a case note describing the date of review, material reviewed, and time spent reviewing the records. If a separate file review is completed, a copy of the document will be kept in the working file and attached to the monthly report. Copies of historical file documents shall be kept with the nurse case manager's case record.

### 3) Correspondence (COR)

Definition / Billing Instructions: The time taken to prepare correspondence, i.e., letters, memo, fax to the department, injured worker, provider, vocational counselor and other governmental agencies, social services, community and/or volunteer resources for the purpose of updating,

clarifying or confirming the medical treatment plan. Bill 1 unit of service for each 6 minutes of time.

Documentation of the service is to include the date when the correspondence was produced, a case note describing the correspondence and time to prepare the correspondence. A copy of the document will be kept in the case record and attached to the monthly report.

#### 4) Research (RE)

Definition / Billing Instructions: The time taken to research medical literature, condition specific. Bill 1 unit of service for each 6 minutes of time.

Documentation of this service is to include the date research was conducted, a summary of the findings of the literature review, the impact of the information on the injured worker's case plan, and time to complete research. If document produced, a copy will be kept in the case record and attach to the monthly report.

#### 5) Report Writing (RW)

Definition / Billing Instructions: The time taken to prepare monthly reports, i.e., initial, progress and closure reports, as well as special reports requested by department representatives. Bill 1 unit of service for each 6 minutes of time. The initial report shall not exceed 2 billable hours per case. Progress and closure reports shall not exceed 1 hour per case.

Documentation of this service is to include the date of the report, a notation in the case notes, a report, (for special reports, note requesting part in case note documentation using appropriate billing code, e.g., PCD or VD) and the time to complete the report. A copy of the report will be kept in the case record and sent to the claims representative on a monthly basis.

#### 6) Record Retrieval (RR)

Definition / Billing Instructions: The time taken to obtain records, reports or evaluations not currently contained in the department's records for case planning. This method of obtaining records should be limited. The most cost-effective method of obtaining records should be used first, prior to use of professional time, e.g., faxing, mailing, etc. Bill 1 unit of service for each 6 minutes of time.

Documentation of this service is to include the date of record retrieval, a case note identifying the record source, summary of records obtained, and the total time (including travel, wait, and photocopying cost) to obtain the report.

#### 7) Team Conference (TC)

Definition / Billing Instructions: The time taken to participate in or conduct a team conference with 3 or more health care professionals, vocational rehabilitation counselors, employer, injured worker and/or representative, or other governmental agencies, social services, community and/or volunteer resources to coordinate activities of patient care, provide for the injured worker's health care needs and/or return to work efforts for the injured worker. Includes documentation of

impact of conference data on the overall case plan. Bill 1 unit of service for each 6 minutes of time. Visit codes are not to be billed for team conferences.

Documentation of this service is to include the date of the conference, a case note, summary of conference findings, analysis, plan of action, and time.

#### TRAVEL (TR)

Definition / Billing Instructions: The time to travel from the nurse case manager's home office or home, whichever is closest, to the person being visited. Bill 1 unit of service for each 6 minutes of time. Transportation costs including parking, ferry, toll fees, cab, and airfare are reimbursable at cost. Travel expenses resulting from single or multiple visits which involve visits or conferences on more than one injured worker must be prorated between the multiple injured workers visited. For example, if the case manager travels to a hospital in Seattle, and visits with 3 injured workers, the costs should be billed by dividing the mileage and travel time between the three cases.

Documentation of the service is to include date of travel, a case note with starting and ending location, whether visit was prorated, mileage, odometer reading start and finish, and other associated transportation expenses, and time.

Mileage costs may be reimbursed at \$.35 per mile or the current Washington state rate for mileage reimbursement. Mileage costs should be billed using the 1224M mileage billing code. Parking, toll, ferry, cab or airfare expenses will be billed with the new 1225M expense billing code. Meals and lodging required outside normal business hours will be paid with prior approval by the claims manager and at the state per diem rate in effect at the time for the area. Meals and lodging and a copy of any original invoice shall be kept in the case record for a minimum of five years.

#### WAIT (WA)

Definition / Billing Instructions: The time to wait to meet with person(s) being visited during scheduled visits. Bill 1 unit of service for each 6 minutes of time to a maximum of 2 hours. Case managers are encouraged to use wait time to conduct other business e.g., phone calls, visits, case planning, file record review, and record retrieval during wait time.

Documentation of the service is to include the date of wait time, a case note with location of visit, time of arrival at appointment, and end time (when appointment visit began).

## **ATTACHMENT B**

### **COVERED AND NON-COVERED EXPENSES**

#### **COVERED EXPENSES:**

**The following expenses will be covered –**

- ❖ Transportation other than mileage, including parking, ferry, toll fees, and cab. Mileage is reimbursed at \$.35 per mile or the current Washington state rate for mileage reimbursement.
- ❖ Meals and lodging required outside normal business hours with prior claims manager approval and at the Washington state per diem rate in effect at the time for the area.
- ❖ Airfare with prior approval from the claim manager.
- ❖ Mileage greater than 150 miles round trip requires prior approval from the claims manager.
- ❖ Fees for obtaining medical records, reports or evaluations per request of department and at no more than the maximum allowable rate of .35 per page.

#### **NON-COVERED EXPENSES:**

**The following expenses will not be covered –**

- ❖ Activities associated with nurse case manager training, e.g., training on office policies and procedures, including report writing and billing.
- ❖ Supervisory activity such as supervisor – nurse case manager visits, case reviews or conferences between supervisor and nurse case manager.
- ❖ Postage, printing or photocopying costs (with the exception of medical records per request of department). See above explanation.
- ❖ Telephone expenses including unanswered phone calls, long-distance phone calls, and facsimile.
- ❖ Time spent on any clerical activity, including processing a referral, file “set up”, typing, copying, mailing, distributing, filing, invoice preparation, record keeping, delivering or picking up mail.
- ❖ Travel time to a post office or a fax machine.
- ❖ Wait time exceeding 2 hours.
- ❖ Fees related to legal work, e.g., deposition, testimony, etc. Legal fees may be charged to the requesting party, but not the claim. Contact the requesting party regarding how legal services are billed.
- ❖ Any other administrative cost not specifically mentioned above.

## **Obesity Treatment**

Type of Service:

Use Type of Service code “9” and the Local codes listed below.

While obesity does not meet the definition of an industrial injury or occupational disease, temporary treatment of obesity may be allowed in some cases. All obesity treatment services require prior authorization. Refer to Provider Bulletin 97-03 for more information.

The attending doctor may request a consultation with a certified dietician or nutritionist (RD) to determine if an obesity treatment program is appropriate for the injured worker.

The procedure codes for obesity treatment are as follows:

1030M	Intake Dietary Evaluation
1034M	Dietary Reevaluation

## **Occupational Therapy**

Type of Service:

Use Type of Service code “9” for HCPCS codes  
Use Type of Service code “3” for CPT codes

**\*\*\* After 12 treatments, you must get new orders from the attending physician and authorization from the claims manager**

## **REPORTING REQUIREMENTS**

**NOTE: CURRENTLY THERE ARE NO PROVISIONS TO PAY OCCUPATIONAL THERAPISTS SEPARATELY FOR REPORTS**

**\*\*\* DO NOT ATTACH REPORTS TO THE BILLS\*\*\***

Send all reports (correspondence) for State Fund claims to:

Department of Labor & Industries  
PO Box 44291  
Olympia WA 98504-4291

- A. Consultation reports
- B. Laboratory and X-ray reports
- C. Special reports and/or narratives to support level of office visit or procedure
- D. Operative reports/anesthesia records



- E. Periodic office notes
- F. Periodic chart notes

**Occup. Thpy con't.  
Optometry/Optician  
Voc Rehab Svcs**

The injured workers' name and claim number must be placed in the upper right corner of each page on any correspondence or report.

The cost invoices for supplies furnished are not routinely required, but may be requested by the department in specific cases.

See WAC 296-20 for additional requirements and report definitions.

### **Optometry/Optician Services**

Type of Service:

- Use Type of Service code "9" for HCPCS codes
- Use Type of Service code "3" for CPT codes

Please refer to WAC 296-20-100 Eye glasses and refractions for more information.

### **Vocational Rehabilitation Services**

Type of Service:

- Use Type of Service code "V" for Vocational codes

This section details the requirements and information Vocational Rehabilitation providers should know and follow in submitting bills.

#### **How to Submit a Bill**

Each provider who works on a referral must bill separately and must list the precise number of units of service worked for each date span on a referral. Each date span billed must have both a start and end date. The provider must also bill for each referral separately. Even if a third party does the billing, the provider receiving the referral is responsible for ensuring that all billing is correct.

In cases where more than one provider delivers services on a referral (e.g., where interns assist on referrals assigned to a VRC, or where one VRC covers for another VRC who is ill), each provider must bill separately for services delivered on the referral. Each provider must use his or her individual provider number, as well as the payee provider number and the referral Identification Number (see section below). The department will reject and not pay bills missing this information. It is important that providers understand that the payee provider identification number of all other providers working on a referral must be the same as the assigned Vocational Rehabilitation Counselor's, or the department will not pay the bill.

**Example:** Acme Rehabilitation employs counselor X, as well as interns Y and Z. Acme may not submit aggregate bills: Acme Rehabilitation must submit a separate bill for Counselor X, Intern Y, and Intern Z—for each referral worked by X, Y, and Z.

For more detailed information about completing billing forms, consult the samples of completed forms, which are located in an attached section.

### Reimbursement Rates

The department has established separate reimbursement rates for different provider specialties. The department will reimburse interns at 85% of the VRC professional rate: forensic evaluators will receive 120% of the VRC professional rate.

The table below lists the professional, travel/wait, and mileage rates for vocational services:

Provider Type	Rate
VRC Professional Rate	\$73/hour
Intern Professional Rate	\$62/hour
Forensic Rate	\$88/hour
Travel/wait Rate	\$36.50/hour
Mileage Rate	Current State Rate/mile

### Fee Caps and Thresholds

As part of the changes to the reimbursement structure, the department has adopted fee caps. Providers must be aware that fee caps are **hard** caps, with **no** exceptions.

***At 100 percent of the fee cap***, the claim manager can either act directly or request that the Vocational Services Consultant conduct a review of the case. The claim manager may re-refer the case to another Vocational Rehabilitation Counselor or make another appropriate decision, based on the circumstances of the claim, such as the following: making a referral to pension, making a forensic referral, or closing the referral for medical instability reasons.

***In situations where the case reaches the fee cap and the department decides another referral is warranted***, the case must be started as quickly as possible (within two to three days). ***Vocational Rehabilitation Counselors must therefore submit closing reports promptly.***

When cumulative payments for a referral have reached the cap, the Remittance Advice sent with the payment will contain an Explanation of Benefits, indicating that the referral has reached its fee cap. The department will adjust the amount of the bill to pay **no more** than the fee cap allows and will authorize **no** payment beyond the cap. It is very important that vocational providers work closely with their billing staffs to monitor costs on their referrals.

Please consult the following fee cap table:

Code	Fee Cap	Equiv. VRC Hours <sup>1</sup>	Comments
0800V 0801V	\$1,500 combined	20.5 hours	
0810V 0811V	\$2,500 combined	34.2 hours	
0821V 0823V 0824V	\$1,100		
0830V 0831V	\$5,000 combined	68.5 hours	
0840V 0841V	\$4,725 combined	64.7 hours	
0881V 0882V 0883V 0884V			
0891V 0892V 0893V 0894V 0895V			Pre-authorization by CM required

### Codes

The following table lists the codes, and their corresponding definitions, for use in billing for vocational services. Reimbursement will occur according to the level of provider described below. Separate codes and provider specialties exist for vocational interns, counselors, and forensic examiners.

**Example:** Intern Y at Acme Rehabilitation bills code 0881V. Result: The department does not pay, because it only authorizes qualified providers to do forensic work.

Code	Description	Counselor Level
	EARLY INTERVENTION	
0800V	Early Intervention Services	VRC
0801V	Early Intervention Services—Intern	Intern

<sup>1</sup> Based on \$73/hour for professional VRC services.

	ASSESSMENT	
0810V	Assessment Services	VRC
0811V	Assessment Services—Intern	Intern
	VOCATIONAL EVALUATION	
0821V	Work Evaluation	VRC
0823V	Pre-job or Job Modification Consultation	VRC
0824V	Pre-job or Job Modification Consultation—Intern	Intern
	PLAN DEVELOPMENT	
0830V	Plan Development Services	VRC
0831V	Plan Development Services—Intern	Intern
	PLAN IMPLEMENTATION	
0840V	Plan Implementation Services	VRC
0841V	Plan Implementation Services—Intern	Intern
	FORENSIC AND TESTIMONY	
0881V	Forensic Services	VRC— Forensic
0882V	Testimony on VRC’s Own Work	VRC
0883V	Testimony on Intern’s Own Work	Intern
0884V	AGO Witness Testimony	VRC
	OTHER	
0891V	Travel/Wait Time	VRC
0892V	Travel/Wait Time—Intern	Intern
0893V	Professional Mileage	VRC
0894V	Professional Mileage—Intern	Intern
0895V	Air Travel	Intern/VRC/ VRC— Forensic

### Date Span Information

When providers are completing billing forms, it is very important to include both start and end dates for the date span of services. Providers must include all services provided during this date span on the bill. They may not submit a new bill for additional services during the same date span. If this circumstance occurs, a “Provider’s Request for Adjustment “ form must be completed to adjust the original charges.

### Units of Service

One unit of service equals 6 minutes of time. The stated hourly rate is equal to 10 units of service. The unit of service for mileage reimbursement is per one mile.

**Example:** the professional VRC rate is \$73 per hour; 1 unit of service (6 minutes) pays \$7.30 (\$73.00/10); 2 units of service (12 minutes) pays 2 x \$7.30 = \$14.60

## Referral Identification Number on Bills

When completing billing forms, a provider must include the referral identification numbers for each submitted bill. The department will deny payment for any bill submitted without a referral identification number. Each department referral has a unique referral identification number.

## Documentation

Documentation that supports billing includes the provider's case notes. Providers should ensure that their case notes include evidence of the time spent on various activities. **Example:** A provider who spends a half-hour on a progress report for a case might specify that half-hour in his or her case notes as ".5 hours preparing progress report."

## Travel/Wait and Mileage

The department developed separate codes for vocational providers' travel/wait time. The department pays for work performed by providers on vocational referrals only from the branch office where the referral was assigned. The department does NOT pay for travel time between two different service locations or branch offices where a provider is working cases.

Providers should bill from the branch office where the referral has been received by the VRC to necessary destinations, such as the following: going to the location of the employer of record, visiting an attending physician's office, and the meeting of a VRC with an injured worker at his or her home.

**Example:** A vocational counselor indicates to the department that he or she is willing to work referrals in Seattle, Yakima, and Longview.

**Result:** The department will reimburse the provider for travel/wait time on cases in each of these three areas, but will not pay for the provider to drive from Seattle to Yakima, or from Longview to work a Seattle or Yakima referral.

Travel/wait is reimbursed at 50% of the standard vocational counselor rate, regardless of referral type or provider specialty. Travel/wait must be pro-rated if more than one referral is included in a particular trip.

Mileage, as determined by the federal rate, is reimbursed at the same rate as that of travel on state business. The department reimburses mileage at the same rate, regardless of referral type or provider specialty.

## For More Information

The **Internet address** where information is available is as follows:

<http://www.lni.wa.gov/rules/>

## Obtaining a Copy of the Vocational Rehabilitation Rules

Providers can obtain a copy of the rules governing vocational services (WAC 296-19A) through the Internet at the following address:

<http://www.lni.wa.gov/rules/voc%20rehab/vocrehabcr103.htm>

## COMPLETING THE “STATEMENT FOR MISCELLANEOUS SERVICES” FORM

The Department of Labor and Industries and service providers are joined in a cooperative process for payment of provider billings. In order to process the billings in a timely manner, the billings must be completed as described. Improperly completed bill forms may be returned to the provider for completion/correction and resubmission.

Completed bill forms **MUST** be typed or printed and be clearly legible. Bills must be submitted on **ORIGINAL** (not photocopies or facsimiles) Statement for Miscellaneous Services forms. All boxes on the form other than those identified, as “not applicable” **MUST** be completed to ensure correct bill adjudication.

***DO NOT STAPLE ANY ATTACHMENTS IN THE BAR CODE AREA AT THE TOP OF THE FORM.***

All boxes on the form other than those identified, as “not applicable” **must** be completed in order to ensure correct bill adjudication.

1. Check the box indicating the applicable category of service. If your particular service category is not listed, check the “OTHER” box (e.g., interpreter services and licensed massage therapists would check the “other” box).
2. **WORKER’S NAME:** Enter worker’s last name, first name and middle name or initial.
3. **SOCIAL SECURITY NUMBER:** Enter worker’s social security number. This information will assist us in identifying the injured worker’s claim number if the claim number is missing or invalid.
4. **CLAIM NUMBER:** Enter the department-assigned claim number for the injury/condition being treated. Omission of this number will result in denial of payment.

Claim numbers are alpha-numeric, consisting of seven characters. The letter identifies the funding source, which is listed below.

STATE FUND  
INDUSTRIAL  
INSURANCE

Claim numbers are six digits, preceded by the letter “B, C, F, G, H, J, K, L, M, N, P, X or Y”. Effective 1/1/2000, Department of Energy (DOE) claims are administered by Self-Insurance. All other DOE claims previous to 1/1/2000, are administered by the State Fund. DOE claims have seven digits with no preceding letter.

Send bills for State Fund claims to

Department of Labor and Industries  
PO Box 44267  
Olympia WA 98504-4267

**CRIME  
VICTIMS**

Crime Victims' Compensation Program claim numbers are either six digits preceded by a "V," or five digits preceded by a "VA, VB, VC, VH or VJ".

Send Bills for Crime Victims claims to

Department of Labor and Industries  
Crime Victims Compensation Program  
PO Box 44520  
Olympia WA 98504-4520

**SELF-  
INSURANCE**

Self-Insurance claim numbers are six digits preceded by an "S, T or W." Bills for all Self-Insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

5. **ADDRESS:** Enter worker's current address.
6. **EMPLOYER'S NAME:** Enter worker's employer's name.
- \* **REIMBURSE INJ WORKER:** Check applicable box indicating whether the injured worker has paid for the services.
7. **DATE OF INJURY/ILLNESS:** The date of injury/illness positively identifies each claim. This is important and **must** be included. A worker may have several claims; therefore, it is vital that the proper claim be identified and charged for services provided.
8. **NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:** Enter name of the doctor referring claimant to you, if applicable.
9. **REFERRING PHYSICIAN PROVIDER NUMBER:** Enter L&I provider account number of referring doctor.
10. **DIAGNOSIS:** ICD9-CM code is not required. However, you must provide a narrative description, e.g., broken glasses, left eye injury, left leg injury, etc. **Designate left or right side of body, when applicable.**
11. **FOR GLASSES:** Indicate "yes" or "no," if applicable to service being provided.
12. **SERVICES RELATED TO HOSPITALIZATION:** Not applicable.
13. **ITEMIZATION OF SERVICES AND CHARGES:**
  - A. **DATE OF SERVICE:** Record one date of service per line.
  - B. **PLACE OF SERVICE:** Enter required 2-digit place of service code. See list of codes in the *Place of Service* section of this booklet or on the reverse side of the bill form.
  - C. **TYPE OF SERVICE:** Enter appropriate type of service code. See list of codes on the last page of this booklet or on the reverse side of the bill form.

- D. **PROCEDURE CODE:** This code identifies the procedures performed or items provided (CPT/HCPCS/Local Code). The department's **Medical Aid Rules and Fee Schedules** lists the procedure code. Enter only one code per line.
- E. **PROCEDURE CODE MODIFIER:** Use only if applicable to your provider type and service provided. Modifiers are listed in the RBRVS section of the current fee schedule.
- F. **DESCRIBE PROCEDURES:** Enter brief description of services or supplies furnished.
- G. **DENTAL TOOTH NUMBER:** Enter tooth number. (Dental Services use only)
- H. **HOME NURSING:** Enter number of hours. (Home Nursing Services use only)
- I. **GLASSES:** Complete this box as indicated. (Optometrist & Optician use only)
- J. **CHARGES:** Total line item charge. (Do not bill negative charges.)
- K. **UNIT:** Enter the total number of days, units, total hours, or miles for the services billed on a line: e.g., rental, lodging, multiple packages of supplies, transportation, etc.

14. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** Enter the name of the provider providing the services (enter last name first) and current address. If there are any changes in the provider's address or status, immediately notify Provider Accounts in writing or via fax at the following address/fax number:

Provider Accounts  
 Department of Labor and Industries  
 PO Box 44261  
 Olympia WA 98504-4261  
 Fax 360-902-4484

PLEASE INCLUDE THE L&I PROVIDER ACCOUNT NUMBER(S) THAT YOU'RE SUBMITTING A CHANGE FOR ON YOUR CORRESPONDENCE.

**Indicating a new address on the bill will not change the department's record of your address and could delay payment.**

- 15. **PROVIDER NUMBER:** Enter the L&I provider account number assigned by the department for the provider of service.
- 16. **TOTAL CHARGE:** Total of **all** charges for services provided.
- 17. **YOUR PATIENT'S ACCOUNT NUMBER:** The number you use to identify your patient's account. This number is for your convenience only.
- 18. **BILL DATE:** The date your billing was prepared.
- 19. **REMARKS:** Enter any further information necessary to explain your charges.
- 20. **REFERRAL ID:** Enter appropriate referral identification number.



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dept of Labor and Industries  
PO Box 44267  
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Medical Equipment/  
Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/  
Nursing Home Services

☐ Glasses

☐ Vocational/  
Retraining

☐ Other

WORKER'S NAME IN FULL First Middle Last			Social Security Number (for ID only)		Claim Number
Address			Employer's Name		
City State ZIP			Reimburse Injured Worker <input type="checkbox"/> Yes <input type="checkbox"/> No		Amount Paid \$
Date of Injury	Name of referring physician or other source				Referring physician provider number

- 1.
- 2.
- 3.
- 4.
- 5.

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted        /        /       

Discharged \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## REFUND CERTIFICATION

I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

[illegible]

Signature:

Bill date:                   /                   /

[illegible]

	Provider number

Total Charge	

---

Address

City	State	ZIP + 4
------	-------	---------

Phone Number
--------------

<p>Your Patient's Account Number</p>
------------------------------------------

Remarks:

Federal tax ID number

☐ EIN ☐ SSN

Referral ID
-------------



# INSTRUCTIONS FOR COMPLETING MISCELLANEOUS SERVICES FORM

- Place an "X" in the box next to the type of service for which you are billing.
- CLAIM NUMBER:** For the injured worker receiving services.

<b>INDUSTRIAL</b>	Claim numbers are six digits, preceded by a "B, C, F, G, H, J, K, L, M, N, P, X or Y." Crime victim claim numbers are six digits preceded by a "V",
<b>INSURANCE</b>	Send bills for Industrial Insurance claims to:
	Department of Labor and Industries
	PO Box 44267
	Olympia WA 98504-4267
	Send bills for Crime Victims claims to:
	Department of Labor and Industries
	PO Box 44520
	Olympia WA 98504-4520

**SELF** Department bill forms are furnished at no charge to the vendor and can be obtained by calling the local department service location.

**INSURANCE** Self-insurance claim numbers are six digits preceded by an "S, T or W". Bills for all self-insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

- INJURED WORKER'S NAME:** Injured worker's full name, last name first.
- SOCIAL SECURITY NUMBER:** Record claimant's social security number. It helpful when the claim number is wrong and the worker's name is common.
- ADDRESS:** The injured worker's most current address.
- EMPLOYER'S NAME:** The injured worker's employer's name. If the claim number is in error, this helps identify the proper claim.
- DATE OF INJURY:** This is important and must be included. One worker may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
- NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services. (Not applicable for Vocational Services billing.)
- REFERRING PHYSICIAN PROVIDER NUMBER:** The Department of Labor and Industries provider account number of the referring physician. The number may be Obtained from the referring physician. (Not applicable for Vocational Services billing.)
- DIAGNOSIS:** Indicate both the ICD9-CM number and the narrative diagnosis for all conditions treated. Designate left or right side of body, when applicable. The Diagnosis presented must be specific. (Not applicable for Vocational Services billings.)
- FOR GLASSES:** Indicate by placing an "X" in the appropriate box.
- SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
- ITEMIZATION OF SERVICES AND CHARGES:**
  - DATE(s) OF SERVICE:** Record the date for each service provided. For consecutive dates of service (e.g., home care, attendant care, equipment rental, etc.) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
  - PLACE OF SERVICE:** Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
  - TYPE OF SERVICE:** A complete list of Type of Service (TOS) codes is printed below. Please refer to that list and place the appropriate code in the space provided.
  - PROCEDURE CODE:** Identifies the procedure used. Procedure codes can be found in the **Medical Aid Rules and Maximum Fee Schedule** distributed by the Department of Labor and Industries.
  - CODE MODIFIER:** A modifier provides the means by which the reporting physician can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" (including the hyphen) after the usual procedure number.
  - DENTAL:** To be used for dental services only.
 

**Tooth Number:** Identify dental services provided by placing the specific tooth number in the appropriate box.
  - HOME NURSING:** To be used for home care only.
 

**Number of Hours or Day:** Identify the number of hours or the number of days that the home care services were provided.

**Hourly or Daily Rate:** Record the rate charged (by the hour or day) for the home care services provided.
  - GLASSES:** To be used for glasses repair or replacement only.
 

Old Rx (OD and OS): If the old prescription is available, specify for both the left and right eyes.

New Rx (OD and OS): Specify the new prescription for both the left and right eyes.
  - CHARGES:** Charges for services provided.
  - UNIT:** The sum total services provided for days, units, or miles, etc.
- PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify Provider Accounts immediately. (Indicating a new address on the bill **will not** change the department's record of address for the provider.
- PROVIDER NUMBER:** Identification number designated by the Department of Labor and Industries for the provider.
- TOTAL CHARGE:** Total of all charges for services provided.
- YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's explanation.
- REMARKS:** Any information necessary that the provider or supplier feels is necessary for further explanation.

## ATTACHMENTS

The following attachments **must be** submitted with billings for appropriate services:

1. X-ray findings	5. Emergency Room reports
2. Lab reports	6. Diagnostic Study reports
3. Office notes	7. Cost invoice of supplies furnished
4. Operative reports	8. Consultation reports

Each attachment must have the corresponding claim number listed in the upper right corner of the attachment.

**DUE TO THE FACT THAT THE DEPARTMENT RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.**  
The following attachment is not acceptable: Office Visit Slips.

## REBILLS

If you do not receive payment or notification from the department within ninety (90) days, services may be rebilled. Rebills should be identical to the original bill; **same** charges, codes and billing dates. Please indicate "Rebill" on the bill.

Any inquiries regarding adjustment of charges must be submitted within ninety (90) days from the date of payment to be considered.

### PLACE OF SERVICE (POS)

- |                        |                                      |
|------------------------|--------------------------------------|
| 1. Inpatient Hospital  | 5. Emergency Room                    |
| 2. Outpatient Hospital | 6. Other Medical/Surgical Facilities |
| 3. Office              | 7. Nursing Home                      |
| 4. Residence           | 8. Other Location                    |

### TYPE OF SERVICE (TOS)

- |                               |
|-------------------------------|
| C Chiropractic Services       |
| D Drugless Therapeutics       |
| I Inpatient                   |
| N Nurse Practitioner Services |
| O Outpatient                  |

- |                                                      |
|------------------------------------------------------|
| P Physical Therapy                                   |
| V Vocational Services                                |
| 3 Medical Services                                   |
| 4 Dental                                             |
| 9 Ancillary Services (attendant, equipment, glasses) |

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dept of Labor and Industries  
PO Box 44267  
Olympia WA 98504-4267

<input type="checkbox"/> Dental Services	<input type="checkbox"/> Glasses
<input type="checkbox"/> Medical Equipment/ Prosthetics-Orthotics	<input type="checkbox"/> Vocational/ Retraining
<input type="checkbox"/> Transportation	<input checked="" type="checkbox"/> Other
<input type="checkbox"/> Home Health/ Nursing Home Services	

## SAMPLE ARNP

[illegible]

Signature: _____  VVVVVVVVVVVV	Bill date: _____  MM / DD / YY	Provider or Supplier name XXXXXX XXX ARNP	Provider number xxxxxxxx	Total Charge \$ XX.XX
		Address 123 E 5 <sup>th</sup> Ave		Phone Number (XXX) XXX-XXXX
		City Any City	State ZIP + 4 WA 00000-0000	Your Patient's Account Number XXXXXXXXXXXXX
Remarks: _____		Federal tax ID number XX-XXXXXX or XXX-XX-XXXX	EIN SSN	
45-072-000 statement for misc services 4/01				Referral ID

NO STAPLES IN  
BAR CODE AREADept of Labor and Industries  
PO Box 44267  
Olympia WA 98504-4267

- ☐ Dental Services ☐ Glasses
- ☐ Medical Equipment/  
Prosthetics-Orthotics ☐ Vocational/  
Retraining
- ☐ Transportation ☒ Other
- ☐ Home Health/  
Nursing Home Services

DO NOT  
WRITE IN  
SPACE >SAMPLE CRNA

WORKER'S NAME IN FULL				First	Middle	Social Security Number (for ID only)				Claim Number			
Last Doe				John		123-45-6789				Y 000000			
Address						Employer's Name							
123 E 5 <sup>th</sup> Ave						ABC Employer							
City				State	ZIP	Reimburse Injured Worker <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				Amount Paid \$			
Any City				WA 98512									
Date of Injury		Name of referring physician or other source								Referring physician provider number			
XX-XX-XX		XXXXX XXXXXXXXXX MD								XXXXXXX			
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM) Designate left or right when applicable.						For glasses, advise if old Rx was Available? <input type="checkbox"/> Yes <input type="checkbox"/> No				<b>REFUND CERTIFICATION</b> I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.  CLAIMANT'S SIGNATURE:			
1. XXX.XX 2. 3. 4. 5.						Give hospitalization dates for inpatient Services  Admitted ____/____/____  Discharged ____/____/____							
FROM DATE OF SERVICE	P O S	T O S	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		Glasses		Charges \$	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly Day rate	OLD RX OD OS	NEW RX OD OS			
3/1/01	xx	N	XXXXX								xx.xx	X	3/1/01

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature:

Bill date:

VVVVVVVVVV

MM / DD / YY

Remarks:

Provider or Supplier name

XXXXX XXX CRNA

Provider number

xxxxxxx

Total Charge

\$ XX.XX

Address

123 E 5<sup>th</sup> Ave

City

Any City

State ZIP + 4

WA 00000-0000

Federal tax ID number

XX-XXXXXXX or  
XXX-XX-XXXX☐

EIN

☐

SSN

Phone Number

(XXX) XXX-XXXX

Your Patient's

Account Number

XXXXXXXXXXXXX



Referral ID

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<input type="checkbox"/> Dental Services	<input type="checkbox"/> Glasses
<input type="checkbox"/> Medical Equipment/ Prosthetics-Orthotics	<input type="checkbox"/> Vocational/ Retraining
<input type="checkbox"/> Transportation	<input checked="" type="checkbox"/> Other
<input type="checkbox"/> Home Health/ Nursing Home Services	

## SAMPLE RNFA

[illegible]

Remarks:

Referral ID



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<input checked="" type="checkbox"/>	Dental Services	<input type="checkbox"/>	Glasses
<input type="checkbox"/>	Medical Equipment/ Prosthetics-Orthotics	<input type="checkbox"/>	Vocational/ Retraining
<input type="checkbox"/>	Transportation	<input type="checkbox"/>	Other
<input type="checkbox"/>	Home Health/ Nursing Home Services		

WORKER'S NAME IN FULL		First	Middle	Social Security Number (for ID only)	Claim Number
Last		Doe	John	A	123-45-6789
Address		123 E 5 <sup>th</sup> Ave			
City		State	ZIP	Employer's Name	
Any City		WA	98512	ABC Employer	
Date of Injury		Name of referring physician or other source			Referring physician provider number
XX-XX-XX		XXXXXX XXXXXXXXXX MD			XXXXXXX

For glasses, advise if old Rx was Available? ☐ Yes ☐ No

Give hospitalization dates for inpatient Services

Admitted                    /                    /

Discharged / /

REFUND CERTIFICATION

I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE: \_\_\_\_\_

[illegible]

CPT codes and descriptions are © 2000 American Medical Association

Remarks:

Referral ID



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<input type="checkbox"/>	Dental Services	<input type="checkbox"/>	Glasses
<input checked="" type="checkbox"/>	Medical Equipment/ Prosthetics-Orthotics	<input type="checkbox"/>	Vocational/ Retraining
<input type="checkbox"/>	Transportation	<input type="checkbox"/>	Other
<input type="checkbox"/>	Home Health/ Nursing Home Services		

SAMPLE DME

[illegible]

Remarks:

Provider or Supplier name <b>XXXXXX XXX</b>	Provider number <b>xxxxxxx</b>	Total Charge <b>\$ XX.XX</b>
Address <b>123 E 5<sup>th</sup> Ave</b>		Phone Number <b>(XXX) XXX-XXXX</b>
City <b>Any City</b>	State ZIP + 4 <b>WA 00000-0000</b>	Your Patient's Account Number <b>XXXXXXXXXXXXXX</b>
Federal tax ID number <b>XX-XXXXXXX or XXX-XX-XXXX</b>	<input type="checkbox"/> EIN <input type="checkbox"/> SSN	
Service (POS) and Type of Service (TOS) codes on back		Referral ID



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<input type="checkbox"/> Dental Services	<input type="checkbox"/> Glasses
<input type="checkbox"/> Medical Equipment/ Prosthetics-Orthotics	<input type="checkbox"/> Vocational/ Retraining
<input type="checkbox"/> Transportation	<input checked="" type="checkbox"/> Other
<input type="checkbox"/> Home Health/ Nursing Home Services	

SAMPLE DRUG &amp; ALCOHOL

[illegible]

Provider or Supplier name XXXXXX XXX	Provider number xxxxxxx	Total Charge \$ XX.XX
Address 123 E 5 <sup>th</sup> Ave		Phone Number (XXX) XXX-XXXX
City Any City	State ZIP + 4 WA 00000-0000	Your Patient's Account Number XXXXXXXXXXXXXX
Federal tax ID number XX-XXXXXX or XXX-XX-XXXX	<input type="checkbox"/> EIN <input type="checkbox"/> SSN	





\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<input type="checkbox"/>	Dental Services	<input type="checkbox"/>	Glasses
<input type="checkbox"/>	Medical Equipment/ Prosthetics-Orthotics	<input type="checkbox"/>	Vocational/ Retraining
<input type="checkbox"/>	Transportation	<input checked="" type="checkbox"/>	Other
<input type="checkbox"/>	Home Health/ Nursing Home Services		

## SAMPLE LMT

[illegible]

Referral ID



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<input type="checkbox"/>	Dental Services	<input type="checkbox"/>	Glasses
<input type="checkbox"/>	Medical Equipment/ Prosthetics-Orthotics	<input type="checkbox"/>	Vocational/ Retraining
<input type="checkbox"/>	Transportation	<input checked="" type="checkbox"/>	Other
<input type="checkbox"/>	Home Health/ Nursing Home Services		

## SAMPLE NURSE CASE MGMT

[illegible]

Referral ID
-------------



**NO STAPLES IN  
BAR CODE AREA**

Dept of Labor and Industries  
PO Box 44267  
Olympia WA 98504-4267

<input type="checkbox"/>	Dental Services	<input type="checkbox"/>	Glasses
<input type="checkbox"/>	Medical Equipment/ Prosthetics-Orthotics	<input type="checkbox"/>	Vocational/ Retraining
<input type="checkbox"/>	Transportation	<input checked="" type="checkbox"/>	Other
<input type="checkbox"/>	Home Health/ Nursing Home Services		

DO NOT  
WRITE IN  
SPACE 

## SAMPLE OBESITY TREATMENT

[illegible]

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Signature: \_\_\_\_\_

Bill date:

MM / DD / YY

Remarks:

Provider or Supplier name

XXXXX XXX

Provider number

XXXXXXX

Total Charge	
--------------	--

\$ XX.XX

---

Address

123 E 5<sup>th</sup> Ave

City  
Any City

State	ZIP + 4
A	00000-0000

Federal tax ID number

XX-XXXXXXX or  
XXX-XX-XXXX

--	--

EIN

114

SSN

Phone Number

(XXX) XXX-XXXX

Your Patient's

Account Number  
XXXXXXXXXXXXXX

Referral ID



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<input type="checkbox"/> Dental Services	<input type="checkbox"/> Glasses
<input type="checkbox"/> Medical Equipment/ Prosthetics-Orthotics	<input type="checkbox"/> Vocational/ Retraining
<input type="checkbox"/> Transportation	<input checked="" type="checkbox"/> Other
<input type="checkbox"/> Home Health/ Nursing Home Services	

## SAMPLE OCCUPATIONAL THERAPY

[illegible]

Remarks:

Provider or Supplier name <b>XXXXXX XXX OT</b>	Provider number <b>xxxxxxx</b>	Total Charge <b>\$ XX.XX</b>
Address <b>123 E 5<sup>th</sup> Ave</b>		Phone Number <b>(XXX) XXX-XXXX</b>
City <b>Any City</b>	State ZIP + 4 <b>WA 00000-0000</b>	Your Patient's Account Number <b>XXXXXXXXXXXXXX</b>
Federal tax ID number XX-XXXXXXX or XXX-XX-XXXX <input type="checkbox"/> EIN <input type="checkbox"/> SSN		
Service (POS) and Type of Service (TOS) codes on back		Referral ID



## 37

Dept of Labor and Industries  
PO Box 44267  
Olympia WA 98504-4267

☐ Dental Services

☐ Medical Equipment/  
Prosthetics-Orthotics

☐ Transportation

☐ Home Health/  
Nursing Home Services

☐ Glasses

☒ Vocational/  
Retraining

☐ Other

DO NOT  
WRITE IN  
SPACE 

## SAMPLE VOCATIONAL REBAB SERVICES

[illegible]

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid. Bill date:

MM / DD / YY

Remarks:

Provider or Supplier name  
Voc Rehab Counselor

Provider number	XXXXXXXX
-----------------	----------

Total Charge	\$ XX.XX
--------------	----------

Address  
123 E 5<sup>th</sup> Ave

Phone Number  
(XXX) XXX-XXXXCity  
Any City

State ZIP + 4  
WA 00000-0000

Your Patient's  
Account Number  
XXXXXXXXXXXXXX

Federal tax ID number  
XX-XXXXXXX

☐ EIN ☐ SSN

Referral ID

XXXXXXXXXXXX



**NO STAPLES IN  
BAR CODE AREA**

Dept of Labor and Industries  
PO Box 44267  
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Medical Equipment/  
Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/  
Nursing Home Services

☐ Glasses

☒ Vocational/  
Retraining

☐ Other

DO NOT  
WRITE IN  
SPACE 

## SAMPLE VOCATIONAL REBAB SERVICES

[illegible]

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

Just and due; that no part of the same has been paid.

Signature: \_\_\_\_\_ Bill date: \_\_\_\_\_

WWWWWWWWWW MM / DD / YY

Remarks:

Provider or Supplier name  
Voc Rehab Intern

Provider number	XXXXXXXX
-----------------	----------

Total Charge	\$ XX.XX
--------------	----------

Address  
123 E 5<sup>th</sup> Ave

Phone Number	(XXX) XXX-XXXX
--------------	----------------

City State ZIP + 4  
Any City WA 00000-0000

Your Patient's Account Number	XXXXXXXXXXXXXX
----------------------------------	----------------

Federal tax ID number  
XX-XXXXXXX ☐ EIN ☐ SSN

Referral ID
XXXXXXXXXXXX



**NO STAPLES IN  
BAR CODE AREA**

Dept of Labor and Industries  
PO Box 44267  
Olympia WA 98504-4267

- ☐ Dental Services
- ☐ Medical Equipment/  
Prosthetics-Orthotics
- ☐ Transportation
- ☐ Home Health/  
Nursing Home Services

☐ Glasses

☒ Vocational/  
Retraining

☐ Other

DO NOT  
WRITE IN  
SPACE 

## SAMPLE VOCATIONAL REBAB SERVICES

[illegible]

Submission of this bill certifies the material furnished, service provided, expenses incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the State of Washington; that the claim is just and due; that no part of the same has been paid.

just and due; that no part of the same has been paid.

Signature: \_\_\_\_\_ Bill date: \_\_\_\_\_

WWWWWWWWWW MM / DD / YY

Remarks:

Provider or Supplier name	Voc Rehab Counselor Forensic
---------------------------	---------------------------------

Provider number	XXXXXXXX
-----------------	----------

Total Charge	\$ XX.XX
--------------	----------

Address  
123 E 5<sup>th</sup> Ave

Phone Number	(XXX) XXX-XXXX
--------------	----------------

City State ZIP + 4  
Any City WA 00000-0000

<p>Your Patient's Account Number</p> <p>XXXXXXXXXXXXXX</p>
----------------------------------------------------------------

Federal tax ID number  
XX-XXXXXXX ☐ EIN ☐ SSN

Referral ID
XXXXXXXXXXXX





## REBILLS

REBILLS should be submitted when:

Your TOTAL BILL has been denied.

Your bill was sent in over 60 days ago and is not yet showing up on your Remittance Advice

You are **required** to REBILL: (WAC 296-20-125)

- For TOTAL BILLS denied because the claim was closed and the claim has now been reopened
- For TOTAL BILLS denied because the claim was first rejected and the claim has now been allowed.
- For TOTAL BILLS denied because a diagnosis was at first not allowed and the diagnosis has now been allowed

Rebills must be received at the department **within one year of the date the final order was issued** which reopened or allowed the claim or diagnosis.

A Rebill should be identical to the original bill: same charges, codes and dates of service.

Rebills should be submitted on new ORIGINAL bill forms. We cannot process photocopies or facsimiles.

## ADJUSTMENTS

A **"Providers Request for Adjustment " form (F245-183-000)** should be submitted to correct an incorrect field on a bill that has **already processed and partially paid**.

Enter the workers name (field 1), their claim number as it appears on your REMITTANCE ADVICE (field 2), the correct claim number if applicable (field 3), the providers name and address (field 4), the ICN (internal control number) of the bill (field 5) as it appears on your REMITTANCE ADVICE (see example headings below for location of the ICN as it appears on your REMITTANCE ADVICE), the performing providers L&I provider number (field 6) and L&I payee number (field 7), if applicable.

Claim #	Name	I	Patient Acct#	ICN	Service Dates From To	Unit	Procedure	Billed Charge
P000000	XXXXXXX	X	XXXXXXXXXX	09936425045000200	121399 121799	1	XXXXX	XX.XX

In the body of the form (field 8) correct only those line item fields that have been paid or denied incorrectly due to incorrect information. Enter only the corrected information (as it should have appeared on the original bill) in the line item fields corresponding to the line item fields on your bill as it appears on your REMITTANCE ADVICE.

### EXAMPLE:

You billed one unit of service on line one but four units were actually completed and should be payable. You've only been paid for one unit. Everything else on the bill is correct. In field 8, on line one of the adjustment form, enter '4' in the 'unit' field. After the adjustment processes you will receive payment for the three units previously unpaid.

Please attach to the adjustment form a copy of your ORIGINAL BILL and a copy of the page of your REMITTANCE ADVICE where your paid bill appears.

#### Request for Reconsideration on **adjustments initiated by the department**

Per legal notice on your REMITTANCE ADVICE, a request for reconsideration of a payment must be made in writing within 20 days of receipt of notice of the adjustment/deduction.

The basis for the request for reconsideration must be other than an objection to the payment amount established by the departments fee schedule.

All supporting documentation relevant to the reconsideration request must be submitted with the request.

**Note:**

DO NOT SUBMIT an adjustment or a rebill for a bill that is reported “in process” on your Remittance Advice. If the bill remains in the “in process” status for **over 60 days**, call our Provider Hotline at 1-800-848-0811. For bills “in process” **under 60 days** you may access the Claim Information Line by calling 1-800-831-5227. Once you access the ‘in process’ bill information, you may choose the ‘zero’ option to be connected to the bill payment section.

Adjustments will appear as the last item on the Remittance Advice as follows:

(See sample RA on page 38)

Your original bill will be reprinted, appearing as a credit for the amount previously paid, (e.g., \$100.00 - CRE).

Your adjustment will usually appear immediately following the credit of your bill.

If an additional payment is allowed, the total amount allowed for the bill will be reported (e.g., \$125.00). The difference between original and adjusted payment will be paid in the warrant (e.g., \$25.00).

If no additional fee is allowable, the amount of the adjustment will be equal to the credit of the previous payment (e.g., \$100.00).

If the original payment is being recouped, the total or partial amount allowed for the bill will be reported (e.g., \$0.00). The "adjusted payment" will recoup the original amount of the bill and report the difference as a credit, CRE (**monies owed back to the department**).

NO STAPLES IN  
BAR CODE AREA



Department of Labor and Industries  
Claims Section  
PO Box 44267  
Olympia WA 98504-4267

## PROVIDER'S REQUEST FOR ADJUSTMENT

CHECK →  
ONE

- ☐ TOTAL OVERPAYMENT  
☐ PARTIAL OVERPAYMENT  
☐ UNDERPAYMENT

**DO NOT  
WRITE IN SPACE**

Please type or print in dark ink

ENTER DATA FROM ORIGINAL REMITTANCE ADVICE				INSTRUCTIONS ARE ENCLOSED			
1) WORKERS NAME (Last, First, Middle)				2) CLAIM NUMBER ON REMIT ADVICE		3) CORRECT CLAIM NUMBER	
4) PROVIDER NAME AND ADDRESS				5) ICN NUMBER ON REMITTANCE ADVICE			
				6) PROVIDER NUMBER			
				7) PAYEE NUMBER			

COMPLETE ONLY THOSE LINE ITEMS PAID/DENIED IN ERROR - ENTER ONLY CORRECTED INFORMATION											
8) Line Item #	a) From/to Date of Service or Covered Dates	b) P O S	c) T O S	d) Procedure Code/ Revenue Code/NDC	e) CODE MOD	f) ICD-9-CM Diagnosis/ Side of Body	g) Tooth Number	h) Charge	i) Days/ Units/ Quantity	j) Days Supply	k) Description
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											

**9. OTHER REMARKS/JUSTIFICATIONS/SPECIAL CIRCUMSTANCES - ATTACH REQUIRED REPORTS - EXPLAIN FULLY**

DATE	SIGNATURE OF PERSON COMPLETING FORM	PHONE NUMBER ( )
------	-------------------------------------	---------------------

F245-183-000 provider's request for adjustment 2/00

DEPARTMENT OF LABOR AND INDUSTRIES  
OLYMPIA, WASH 98504

007589

REMITTANCE ADVICE

PROVIDER'S NAME  
PROVIDER'S STREET ADDRESS  
CITY, STATE ZIP

PAYEE PROVIDER NUMBER 0000000 REMIT ADVICE # XXXXXX WARRANT REGISTER NUMBER 60048 DATE 03/30/2001 PAGE X

CLAIM NUMBER	NAME	I	PATIENT ACCT/RX NUMBER	ICN	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	BILLED CHARGES	ALLOWED	TAX OR NON- COVD CHARGES	PAYABLE	EOB CODES
PAID BILLS - MISCELLANEOUS BILL													
Y000000	XXXXXXXX	X	XXXXXXXXXXXX	00111525045000200	011301	011701	1	XXXXXX	XX.XX	XX.XX	0.00	XX.XX	
					011301	011701	1	XXXXXX	XX.XX	XX.XX	0.00	XX.XX	
					011301	011701	1	XXXXXX	XX.XX	XX.XX	0.00	XX.XX	
					011301	011701	1	XXXXXX	XX.XX	XX.XX	0.00	XX.XX	
***BILL TOTAL *****									XX.XX	XX.XX	0.00	XX.XX	
***PAID BILLS TOTAL – MISCELLANEOUS BILLS									XX.XX	XX.XX	0.00	XX.XX	
BILLS-IN-PROCESS - MISCELLANEOUS BILL													
X000000	XXXXXXXX	X	XXXXXXXXXXXX	00111525030003700	012201	012201	1	XXXXXX	X.XX	X.XX	0.00	X.XX	
					012201	012201	2	XXXXXX	XX.XX	XX.XX	0.00	XX.XX	
***BILL TOTAL *****									XX.XX	XX.XX	0.00	XX.XX	559
***BILLS PENDING TOTAL – MISCELLANEOUS BILLS									XX.XX	0.00	0.00	0.00	
DENIED BILLS – PRACTITIONER BILL													
X000000	XXXXXXXX	X	321	00111525004006000	012101	012501	1	###M##	XX.XX	0.00	0.00	0.00	045
					012101	012501	1	###A#	XXX.XX	0.00	0.00	0.00	045
					012101	012501	1	M####	XXX.XX	XXX.XX	0.00	XXX.XX	
***BILL TOTAL *****									XXX.XX	XXX.XX	0.00	XXX.XX	
***DENIED BILL TOTAL – MISCELLANEOUS BILLS									XXX.XX	XXX.XX	0.00	XXX.XX	
ADJUSTMENT – BILLS - MISCELLANEOUS BILL													
X000000	XXXXXXXX	X	321	00111725007101500	012101	012501	1	###M##	XX.XX-	0.00-	0.00	0.00-	
					012101	012501	1	###A#	XXX.XX-	0.00-	0.00	0.00-	
					012101	012501	1	M####	XXX.XX-	XXX.XX-	0.00	XXX.XX-	
***BILL TOTAL *****									XXX.XX-	XXX.XX-	0.00	XXX.XX-	CRE
X000000	XXXXXXXX	X	321	00111725007201500	012101	012501	1	M####	XX.XX	XX.XX	0.00	XX.XX	
					012101	012501	1	A####	XXX.XX	XXX.XX	0.00	XXX.XX	
					012101	012501	1	M####	XXX.XX	XXX.XX	0.00	XXX.XX	
***BILL TOTAL *****									XXX.XX	XXX.XX	0.00	XXX.XX	
**ADJUSTMENT TOTALS – MISCELLANEOUS BILL									XXX.XX	XXX.XX	0.00	XXX.XX	

EOB 045 – Denied. Type Service/Procedure Code is invalid. Refer to current Fee Schedule for valid code.

## TYPE OF SERVICE CODES:

C	Chiropractic Services	P	Physical Therapy
D	Drugless Therapeutics	V	Vocational Services
I	Inpatient	3	Medical Services
N	Nurse Practitioner Services	4	Dental
O	Outpatient	9	Ancillary Services (attendant, equipment, glasses)

## PLACE OF SERVICE CODES:

- 11. Office
- 12. Patient's Home
- 21. Inpatient Hospital
- 22. Outpatient Hospital
- 23. Emergency Rm – Hospital
- 24. Ambulatory Surgical Ctr
- 25. Birthing Ctr
- 26. Military Trmt Facility
- 31. Skilled Nursing Facility
- 32. Nursing Facility
- 33. Custodial Care Facility
- 34. Hospice
- 41. Ambulance – Land
- 42. Ambulance – Air or Water
- 50. Federally Qualified Hlth Ctr
- 51. Inpatient Psychiatric Facility
- 52. Psychiatric Facility Partial Hospitalization
- 53. Community Mental Health Ctr
- 54. Intermediate Care Facility/Mentally Retarded
- 55. Residential Substance Abuse Trmt Facility
- 56. Psychiatric Residential Trmt Ctr
- 60. Mass Immunization Ctr
- 61. Comprehensive Inpatient Rehabilitation Facility
- 62. Comprehensive Outpatient Rehab Facility
- 65. End Stage Renal Disease Trmt Facility
- 71. State or Local Public Health Clinic
- 72. Rural Hlth Clinic
- 81. Independent Laboratory
- 99. Other Unlisted Facility

Directory:  
FIELD SERVICE OFFICES

Aberdeen:	415 West Wishkah, Suite 1B Aberdeen WA 98520-0013 (360) 533-8200	Okanogan:	1234 2 <sup>nd</sup> Avenue S Okanogan WA 98840-0632 (509) 826-7345
Bellevue:	616 120 <sup>th</sup> Avenue NE, Suite C201 Bellevue WA 98005-3037 (425) 990-1400	Port Angeles:	1605 East Front Street, Suite C Port Angeles WA 98362-4628 (360) 417-2700
Bellingham:	1720 Ellis Street, Suite 200 Bellingham WA 98225-4600 (360) 647-7300	Pullman:	1250 Bishop Blvd SE, Suite G PO Box 847 Pullman WA 99163-0847 (509) 334-5296 1-800-509-0025
Bremerton:	500 Pacific Avenue, Suite 400 Bremerton WA 98337-1904 (360) 415-4000	Seattle:	300 W Harrison Street Seattle WA 98119-4081 (206) 281-5400
Colville:	298 South Main, Suite 203 Colville WA 99114-2416 (509) 684-7417 1-800-509-9174	Spokane:	901 N Monroe Street, Suite 100 Spokane WA 99201-2149 (509) 324-2600 1-800-509-8847
East Wenatchee:	519 Grant Road East Wenatchee WA 98802-5459 (509) 886-6500 1-800-292-5920	Tacoma:	950 Broadway Suite 200 Tacoma WA 98402-4453 (253) 596-3800
Everett:	729 100 <sup>th</sup> St SE Everett WA 98208-3727 (425) 290-1300	Tukwila:	12806 Gateway Drive PO Box 69050 Seattle WA 98168-1050 (206) 248-8240
Kennewick:	500 N Morain, Suite 1110 Kennewick WA 99336-2683 (509) 735-0100 1-800-547-9411	Tumwater:	PO Box 44851 7273 Linderson Way SW Olympia WA 98504-4851 (360) 902-5799
Longview:	900 Ocean Beach Hwy Longview WA 98632-4013 (360) 575-6900	Vancouver:	312 SE Stonemill Dr, Suite 120 Vancouver WA 98684-3508 (360) 896-2300
Moses Lake:	3001 W Broadway Ave Moses Lake WA 98837-2907 (509) 764-6900	Walla Walla:	1815 Portland Avenue, Suite 2 Walla Walla WA 99362-2246 (509) 527-4437
Mount Vernon:	525 E College Way, Suite H Mount Vernon WA 98273-5500 (360) 416-3000	Yakima:	15 W Yakima Avenue, Suite 100 Yakima WA 98902-3480 (509) 454-3700 1-800-354-5423

**\* indicates Regional Office  
(Revised 4/11/2001)**

**Copyright Information**

---

CPT five-digit codes, descriptions, and other data only are copyright 2000 American Medical Association. All Rights Reserved.

No fee schedules, basic units, relative values or related listings are included in CPT.

AMA does not directly or indirectly practice medicine or dispense medical services.

AMA assumes no liability for data contained or not contained herein.